Connolly	Huffman	Moulton
Conyers	Huizenga	Mullin
Cook	Hultgren	Murphy (FL)
Cooper	Hunter	Murphy (PA)
Correa	Hurd	Nadler
Costa	Issa	Napolitano
Costello (PA)	Jackson Lee	Neal
Courtney	Jayapal	Newhouse
Cramer	Jeffries	Noem
Crawford	Jenkins (KS)	Nolan
Crist	Jenkins (WV)	Norcross
Crowley	Johnson (GA)	Nunes
Cuellar	Johnson (LA)	O'Halleran
Culberson	Johnson (OH)	O'Rourke
Cummings	Johnson, E. B.	Olson
Curbelo (FL)	Johnson, Sam	Palazzo
Davidson	Jones	Pallone
Davis (CA)	Jordan	Palmer
Davis, Danny	Joyce (OH)	Panetta
Davis, Rodney	Kaptur	Pascrell
DeFazio	Katko	Paulsen
DeGette	Keating	Pearce
Delaney	Kelly (IL)	Pelosi
DeLauro	Kelly (MS)	Perlmutter
DelBene	Kelly (PA)	Perry
Demings	Kennedy	Peters
Denham	Khanna	Peterson
Dent	Kihuen	Pingree
DeSantis	Kildee	Pittenger
DeSaulnier	Kilmer	Pocan
DesJarlais	Kind	Poe (TX)
Deutch	King (NY)	Poliquin
Diaz-Balart	Kinzinger	Polis
Dingell	Knight	Posey
Doggett	Krishnamoorthi	Price (NC)
Donovan	Kuster (NH)	Quigley
Doyle, Michael F.	Kustoff (TN)	Raskin
	Labrador	Ratcliffe
Duffy	LaHood	Reed
Duncan (SC)	LaMalfa	Reichert
Duncan (TN)	Lamborn	Renacci
Dunn	Lance	Rice (NY)
Ellison	Langevin	Rice (SC)
Emmer	Larsen (WA)	Richmond
Engel	Larson (CT)	Roby
Eshoo	Latta	Roe (TN)
Espaillat	Lawrence	Rogers (AL)
Esty	Lawson (FL)	Rogers (KY)
Evans	Lee	Rohrabacher
Farenthold	Levin	Rokita
Faso	Lewis (GA)	Rooney, Francis
Ferguson	Lewis (MN)	Rooney, Thomas J.
Fitzpatrick	Lieu, Ted	
Fleischmann	Lipinski	Ros-Lehtinen
Flores	LoBiondo	Rosen
Fortenberry	Loebsack	Roskam
Foster	Lofgren	Ross
Foxx	Long	Rothfus
Frankel (FL)	Loudermilk	Rouzer
Franks (AZ)	Love	Roybal-Allard
Frelinghuysen	Lowenthal	Royce (CA)
Gabbard	Lowey	Ruiz
Gaetz	Lucas	Ruppersberger
Gallagher	Luetkemeyer	Russell
Garamendi	Lujan Grisham, M.	Rutherford
Garrett		Ryan (OH)
Gibbs	Luján, Ben Ray	Sánchez
Gohmert	Lynch	Sanford
Gonzalez (TX)	MacArthur	Sarbanes
Goodlatte	Maloney, Carolyn B.	Scalise
Gosar		Schakowsky
Gottheimer	Maloney, Sean	Schiff
Gowdy	Marchant	Schneider
Granger	Marino	Schrader
Graves (GA)	Marshall	Schweikert
Graves (LA)	Massie	Scott (VA)
Graves (MO)	Mast	Scott, Austin
Green, Al	Matsui	Scott, David
Green, Gene	McCarthy	Sensenbrenner
Griffith	McCaul	Serrano
Grijalva	McClintock	Sessions
Grothman	McCollum	Sewell (AL)
Guthrie	McEachin	Shea-Porter
Gutiérrez	McGovern	Sherman
Hanabusa	McHenry	Shimkus
Harper	McKinley	Shuster
Harris	McMorris Rodgers	Simpson
Hartzler		Sires
Hensarling	McNerney	Smith (MO)
Herrera Beutler	McSally	Smith (NE)
Hice, Jody B.	Meadows	Smith (NJ)
Higgins (LA)	Meehan	Smith (TX)
Higgins (NY)	Meeks	Smucker
Hill	Meng	Soto
Himes	Messer	Speier
Holding	Mitchell	Stefanik
Hollingsworth	Moolenaar	Stewart
Hoyer	Mooney (WV)	Stivers
Hudson	Moore	Suozzi
Swalwell (CA)	Valadao	Webster (FL)
Takano	Vargas	Welch
Taylor	Veasey	Wenstrup
Tenney	Vela	Westerman
Thompson (CA)	Velázquez	Williams
Thompson (MS)	Visclosky	Wilson (FL)
Thompson (PA)	Wagner	Wilson (SC)
Thornberry	Walberg	Wittman
Tiberi	Walden	Womack
Tipton	Walker	Woodall
Titus	Walorski	Yarmuth
Tonko	Walters, Mimi	Yoder
Torres	Walz	Yoho
Trott	Wasserman Schultz	Young (AK)
Turner		Young (IA)
Upton	Weber (TX)	Zeldin

NOES—7

Fudge	Heck	Watson Coleman
Gallego	Smith (WA)	
Hastings	Waters, Maxine	

NOT VOTING—6

King (IA)	Rush	Slaughter
Payne	Sinema	Tsongas

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1352

Ms. ESHOO changed her vote from ''no'' to ''aye.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. HASTINGS. Mr. Speaker, during rollcall Vote number 184 on H.R. 372, I mistakenly recorded my vote as "nay" when I should have voted "yea."

Mr. GALLEGO. Mr. Speaker, I cast a vote in error. On the rollcall Vote No. 184, I had intended to vote in the follow manner: rollcall Vote No. 184—Competitive Health Insurance Reform Act of 2017—"yes."

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2017

Ms. FOXX. Mr. Speaker, pursuant to House Resolution 210, I call up the bill (H.R. 1101) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 210, in lieu of the amendment recommended by the Committee on Education and the Workforce printed in the bill, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–9 is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 1101

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Business Health Fairness Act of 2017''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

''(1) A plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2017.

''(2) A plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries.

''(3) A plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2017.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2017, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

''(1) the affiliated member was an affiliated member on the date of certification under this part; or

''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

''(i) setting contribution rates based on the claims experience of the plan; or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

''SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage; or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions;

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

''(iii) a reserve sufficient for any other obligations of the plan; and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination. Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess/stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan's projected levels of participation or claims, the nature of the plan's liabilities, and the types of assets available to assure that such liabilities are met.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) A failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

''(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2017, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

''(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

''(A) A representative of the National Association of Insurance Commissioners.

''(B) A representative of the American Academy of Actuaries.

''(C) A representative of the State governments, or their interests.

''(D) A representative of existing self-insured arrangements, or their interests.

''(E) A representative of associations of the type referred to in section 801(b)(1), or their interests.

''(F) A representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation such interim reports as it considers appropriate.

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan,

and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary, and applicable provisions of law;

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

''(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

''(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2017.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

''(3) such tax is otherwise nondiscriminatory; and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

''(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2017, a person eligible to be a member of the sponsor or one of its member associations.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (f)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805''; and

(C) by adding at the end the following new subsection:

''(f)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

''(A) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

''(B) relating to prompt payment of claims.

''(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(5) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 812, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(d) of such Act (29 U.S.C. 1144(d)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2017 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2022, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8. RULES GOVERNING ASSOCIATION HEALTH PLANS

''801. Association health plans.
''802. Certification of association health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''807. Requirements for application and related requirements.
''808. Notice requirements for voluntary termination.
''809. Corrective actions and mandatory termination.
''810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

''811. State assessment authority.
''812. Definitions and rules of construction.''.

SEC. 3. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after ''control group,'' the following: ''except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,'';

(2) in clause (iii), by striking ''(iii) the determination'' and inserting the following:

''(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, an interest of greater than 25 percent may not be required as the minimum interest necessary for common control, or

''(II) in any other case, the determination'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 4. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended by adding at the end the following new subsection:

''(c) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement described in section 3(40)(A)(i),

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended by inserting ''(a) IN GENERAL.—'' before ''In accordance'', and by adding at the end the following new subsection:

''(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

''(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

''(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 6. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this Act shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act within 1 year after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

The SPEAKER pro tempore. The bill shall be debatable for 1 hour equally divided and controlled by the chair and

ranking minority member of the Committee on Education and the Workforce.

After 1 hour of debate, it shall be in order to consider the further amendment printed in House Report 115–51, if offered by the Member designated in the report, which shall be considered read and shall be separately debatable for the time specified in the report equally divided and controlled by the proponent and an opponent.

The gentlewoman from North Carolina (Ms. FOXX) and the gentleman from Virginia (Mr. SCOTT) each will control 30 minutes.

The Chair recognizes the gentlewoman from North Carolina.

GENERAL LEAVE

Ms. FOXX. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 1101.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from North Carolina?

There was no objection.

Ms. FOXX. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of H.R. 1101, the Small Business Health Fairness Act of 2017.

Mr. Speaker, this week marks 7 years since ObamaCare was signed into law. We all remember the promises former President Obama and Washington Democrats made at the time.

Families were promised that their healthcare costs would go down. They were promised more choices and more competition. Small businesses and their employees were promised greater access to affordable health care.

But for 7 years, we have watched as all of those promises were broken. For 7 years, we have heard from families and small businesses across the country that have seen their healthcare costs skyrocket and their choices diminish.

Members of the House Education and the Workforce Committee recently heard from Scott Bollenbacher, an Indiana small-business owner with 11 full-time employees. The company has been forced to switch healthcare plans twice now under ObamaCare, and their only viable option this year was a plan with a 78 percent premium increase.

Mr. Bollenbacher is one of countless small-business owners struggling to make ends meet under a failed government takeover of health care. Because of ObamaCare, 300,000 small-business jobs have been destroyed, including nearly 8,000 in my home State of North Carolina.

□ 1400

Additionally, an estimated 10,000 small businesses nationwide have closed their doors, and small business employees have lost $19 billion each year in wages.

It should come as no surprise that, since 2008, the share of small businesses with fewer than 10 employees offering health coverage has dropped 36 percent. It is not that they don't want to; it is that onerous mandates and regulations have made it simply unaffordable to do so.

Fortunately, relief is on the way. This week we are not only moving to repeal ObamaCare, we are also advancing positive reforms that promote affordable coverage for working families, including the Small Business Health Fairness Act.

As its title implies, this important legislation is about fairness for small businesses and their employees. Today, small businesses are on an unfair playing field with larger companies and unions when it comes to health care. Large businesses have the ability to negotiate for more affordable healthcare costs for their employees, but small businesses do not have the same advantage. Because of their size, small businesses have limited bargaining power, which means their employees can end up paying more for health insurance.

With millions of Americans employed by a small business, it is long past time to level the playing field. That is exactly what this commonsense legislation is about. This bill would empower small businesses to band together through association health plans, or AHPs, to purchase high-quality health care at a lower cost for workers.

This bill represents a first step toward a more competitive health insurance market that crosses State lines. Under H.R. 1101, small businesses in different States could join together through a group health plan. These plans would have strong protections and solvency requirements to ensure workers can count on healthcare coverage when they and their families need it.

What does all of this mean: more choices, more freedom, and more affordable health care for working families and small-business owners like Scott Bollenbacher. This is a better way, one that stands in stark contrast to ObamaCare's failed approach. Instead of more mandates, this bill empowers individuals to access the high-quality, affordable healthcare plan that meets their needs.

I want to thank my colleague Representative SAM JOHNSON for championing, for years, the positive reforms in this bill.

I urge Members to vote ''yes'' on H.R. 1101 so we can level the playing field for small businesses and expand affordable health coverage for working families.

Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today we are considering a bill that purports to make it easier for small businesses to obtain coverage, and tomorrow we will vote on a bill that will take away health insurance coverage for 24 million Americans and force everyone else to pay more for less. So not only are we considering a bill today that will make things worse, we are considering it a day before we vote on ruining health security for working families in order to provide tax cuts for the wealthy.

As we debate the possible replacement of the Affordable Care Act, I think it is instructive that we look back at what the situation was before the ACA passed.

Listening to some, you would think that the costs weren't going up at all. In fact, costs were going through the roof before the ACA, and small businesses, particularly, were having spectacular cost increases—and that is until somebody got sick. At that point, you were unlikely to be able to afford any insurance at all.

Every year before the ACA, small businesses were dropping insurance right and left, particularly after somebody got sick. Also, before the Affordable Care Act, people with preexisting conditions couldn't get insurance. Women were paying more than men. Millions of people were losing their insurance every year.

Since then, the costs have continued to go up, but at the lowest rate in the last 50 years. People with preexisting conditions can get insurance at the standard rate. Small businesses can cover their employees through the Affordable Care Act at the average cost, whether or not anybody in their small business has cancer or diabetes. Women are not paying more than men. Instead of millions of people losing their insurance every year, 20 million more people have insurance.

In addition to that, families now enjoy strong consumer protections. The full name of the Affordable Care Act is the Patient Protection and Affordable Care Act. Now there are no caps on what an insurance company pays, and they can't cancel your policy for anything other than nonpayment. Preventive services such as cancer screenings are available with no copay or deductible. Those up to 26 can stay on their parents' policy, and the doughnut hole is being closed.

The ACA did not cure every problem, but it went a long way to making Americans healthier and giving them some economic security. It could have gone further if, in the past 7 years, Republicans would have been willing to work with Democrats to build on the progress instead of forcing over 60 votes to repeal all parts of the Affordable Care Act.

If we do anything now, we ought to improve the situation, not make it worse. The Republican plan makes things worse. The CBO analysis concluded that 24 million fewer people will have insurance, and most of those that get insurance in the future will be paying more for policies that don't deliver as much.

For seniors, particularly, the costs will skyrocket. And, in fact, the prediction that the rates will go down in

the future are a result of the conclusion that so few seniors will be able to buy insurance that they will no longer be in the insurance pool.

The insurance pool would be younger, and, therefore, the costs would go down. But that is only because seniors won't be able to afford the insurance. Therefore, the insurance pool will be younger and cheaper for those who can actually afford it, but that is not a good thing for seniors who need the insurance and can't afford it.

So today we are considering another failed policy. The association plan ideas have been studied for years, and it has been concluded that it is a bad idea. Under the Affordable Care Act, essentially everybody pays average. If you change that arithmetic so some can pay a little less, then arithmetic matters. Everybody else is going to pay a little more.

In the association plans, quite frankly, I will admit, they will always work for the few that can get into them. That is because, if you can draw out your own group, if they are healthier than average and can pay less, they will pay less and the association will work. But if you pull out a group and it turns out they are a little sicker than average and the bids come in above average, then the association will dissolve and everybody will go back into the insurance pool.

So if you can pull out a group, they will always pay less until somebody gets sick, and then everybody jumps back into the insurance pool. The higher cost groups will be left behind. The lower cost groups will segment out, and then the rates will go down for a few and up for everybody else.

This is exactly why the American Academy of Actuaries has said that expanding association plans ''could result in unintended consequences such as market segmentation that could threaten . . . viability and make it more difficult for high-cost individuals and groups to obtain coverage.''

One of the other problems is a lack of regulation. If a group is allowed to circumvent State regulations, that policy may be cheaper because the policy is not as good.

There are a lot of ways that you can save money. You can pull out a group of just young men and save on maternity benefits. That would be cheaper for them but more expensive for everybody else.

And what happens when a new spouse needs coverage and tries to get it as an optional benefit? They won't be able to afford it.

Workers and businessowners are likely to get fewer benefits under the association approach and will be disadvantaged compared to those in the regular pool getting comprehensive benefits.

This is exactly why Consumers Union has stated that the legislation is ''likely . . . to provide minimal and nonuniform benefits.''

Mr. Speaker, this bill will make it easier to set up these kinds of associations and let them avoid State regulations, which could require solvency, nice solvency requirements, and consumer protections. The protections in this bill are not sufficient to protect consumers, and most States would require stronger capital requirements than the bill requires.

Much like the Republican replacement bill, this bill goes in the wrong direction, so I urge my colleagues to vote ''no.''

Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I yield 6 minutes to the gentleman from Texas (Mr. SAM JOHNSON), the author of the bill.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I thank the gentlewoman for yielding.

I would like to start off by thanking Chairwoman FOXX and Chairman WALBERG for their strong support of my bill, the Small Business Health Fairness Act.

Mr. Speaker, the legislation before us today is on an issue that has long been near and dear to my heart: association health plans. Association health plans would allow small businesses to join together and provide healthcare coverage just like large corporations and unions do today.

Association health plans are also a central part of replacing ObamaCare with commonsense solutions.

You know, ObamaCare has been an absolute disaster. My constituents in Collin County, Texas, have shared with me their negative experiences with it since it became law nearly 7 years ago.

One of the groups hardest hit by ObamaCare is small businesses, the backbone of our economy. Since 2008, over one-third of businesses with fewer than 10 employees offering health insurance have dropped insurance; and, you know, that is just wrong.

Because ObamaCare is failing, we need to repeal it and replace it with better solutions for the American people. One of these solutions is my association health plan bill.

What my bill does is simply allow small businesses to join together through trade or professional organizations. As we all know, the basic rule of insurance is the bigger the risk pool, the lower the cost.

Furthermore, my bill allows small businesses to join together across State lines. My bill would also free small businesses from costly and burdensome State and Federal requirements. This isn't anything different from what large employers and unions already do. My bill is simply about leveling the playing field for small businesses and their hardworking employees.

This bill also has wide support from the business community, including the United States Chamber of Commerce, the National Federation of Independent Business, the National Retail Federation, and the International Franchise Association.

Not everyone knows this, but I was a small-business owner myself between my time in the Air Force and coming to Congress. In fact, I established a home building business in north Texas from scratch, so I can understand where small businesses are coming from.

For example, Bob Gibbons and his wife own a commercial real estate business in my hometown of Plano, Texas. They have had a tough time obtaining good, affordable health insurance, a problem that has gotten worse since ObamaCare.

Bob sums up this entire issue pretty well in two sentences: ''Why should someone's status as an employee give them preferential right to decent group health coverage? Entrepreneurs are penalized when they start a small business because they can't get comparable coverage.''

□ 1415

Bob's experience underscores the entire point behind the Small Business Health Fairness Act.

Mr. Speaker, I include Bob's letter in the RECORD, along with letters from the cities of Frisco, Richardson, and Anna in my district.

REATA COMMERCIAL REALTY, INC.,
Plano, TX, March 2, 2017.

Re Association Health Plans.

Hon. SAM JOHNSON,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE JOHNSON: I would like to register my support of your recently introduced bill, H.R. 1101, which would provide for association health plans. I am a small business owner in your district in Plano, Texas. My wife and I have been on a roller coaster of health coverage over the years. We were covered by employer plans when I was an employee (pre-ACA). Then we had to negotiate for an individual plan when I started my own business (pre-ACA). Then we were again covered by an employer plan when my wife went to work (post-ACA). And now that she works with me, we must navigate the purchase of an individual plan again, but in the post-ACA failure environment.

I have always thought it was ridiculous that the only decent health coverage was available to employees of companies that provided it. Why should someone's status as an employee give them a preferential right to decent group health coverage? Entrepreneurs are penalized when they start a small business because they can't get comparable coverage.

I was thrilled when I ran into Gabi Pate at a Plano Chamber of Commerce Public Policy Committee meeting yesterday and heard you were trying to help. Association health plans would be a step in the right direction. At least then I could get in on a group plan through trade associations, a chamber of commerce or another qualified group. I truly hope that the bill will allow for portability of that health coverage, however, so I can leave the association if I choose and still have coverage.

Thank you for your leadership in this area. Please don't hesitate to contact me if you have any questions.

Sincerely,

BOB GIBBONS.

FRISCO CHAMBER OF COMMERCE,
Frisco, TX, March 22, 2017.

On behalf of the Frisco Chamber of Commerce in Frisco, Texas, I write in strong support of the Small Business Health Fairness Act. The Frisco Chamber of Commerce provides advocacy support for over 1,300 businesses of all sizes. We consistently hear from our small business members about the hardship in providing appropriate and adequate healthcare for their employees at an affordable price. This legislation will increase small businesses' bargaining power with health insurance providers and ensure a level playing field for smaller entities that want to help their workers and families with healthcare costs.

Locally owned small businesses are a huge contributor in the fabric of a business community. It is through the small and medium businesses that we see the greatest job growth. It is through the small and medium businesses that we see the greatest increase in retail spending in the local communities. However, while many see the benefit of a strong small business community, they have been neglected in being able to negotiate for competitive pricing in healthcare costs.

For these reasons, the Frisco Chamber of Commerce strongly supports the Small Business Health Fairness Act, which will allow small businesses the opportunity to band together to provide their employees with better, more affordable health insurance coverage. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant.

Sincerely,

TONY FELKER,
President/CEO.

RICHARDSON, TEXAS,
CHAMBER OF COMMERCE,
Richardson, TX, March 21, 2017.

Re Association Health Plans.

Hon. SAM JOHNSON,
House of Representatives,
Washington DC.

DEAR CHAIRMAN JOHNSON: On behalf of the Richardson Chamber of Commerce, a 5-star chamber, I write in strong support of the Small Business Health Fairness Act. This legislation will increase small businesses' bargaining power with health insurance providers and ensure a level playing field for smaller entities that want to help their workers and families with health care costs. The Richardson Chamber of Commerce commends you for your longstanding leadership on this important issue to the small business community. With more than 650 member organizations, the Richardson Chamber of Commerce continues the goal of its founding fathers to serve as the cornerstone of economic and community development for the city of Richardson. In order to continue that growth, our small businesses must be allowed to offer affordable healthcare to their employees.

While the small business community's economic output is great, its negotiating power in the health care market is at a competitive disadvantage. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to ''self-insure'' and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer competitively priced health insurance.

For these reasons, the Richardson Chamber of Commerce and our member companies, strongly support the Small Business Health Fairness Act, which will allow small businesses the opportunity to band together to provide their employees with better, more affordable health insurance coverage. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant.

The Richardson Chamber commends your efforts to provide small businesses with health care options in a thoughtful and constructive manner. We look forward to working with you on this key legislation.

Sincerely,

WILLIAM C. SPROULL,
President and CEO.

GREATER ANNA
CHAMBER OF COMMERCE,
Anna, TX, March 21, 2017.

Hon. SAM JOHNSON,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE JOHNSON: On behalf of the Greater Anna Chamber of Commerce and our more than 200 members, including a majority of small business, I would like to show our support of the H.R. 101, the Small Business Health Fairness Act. There are many small businesses in our community that cannot currently economically and efficiently afford healthcare for their employees. We hope this legislation will help ease that affordability on both our businesses and employees.

With better access to healthcare, employees could be more willing to work at these smaller businesses instead of only working for larger corporations. This will help our local community by keeping our employees closer to their home, families and children's schools. Again, we support for Small Business Health Fairness Act and look forward to a better solution to our current healthcare problem.

Best Regards,

KEVIN HALL,
Executive Director,
Greater Anna Chamber of Commerce.

Mr. SAM JOHNSON of Texas. Mr. Speaker, by allowing small businesses to band together, they can collectively purchase more affordable health insurance for their employees.

Let's get this commonsense plan passed. Let's help those who power our economy be able to get the health care they want, need, and deserve for themselves and their workers.

Mr. Speaker, I urge all my colleagues to vote in favor of H.R. 1101.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 4 minutes to the gentleman from New York (Mr. ESPAILLAT).

Mr. ESPAILLAT. Mr. Speaker, I rise today in opposition to H.R. 1101, the Small Business Health Fairness Act.

Mr. Speaker, the concept of association health plans, AHPs, is nothing new. Versions of this bill have been around for many years. They don't work.

Currently, AHPs are regulated by the States, ensuring the ability to protect consumers. H.R. 1101, however, will yank association health plans from the realm of State oversight by federally certifying them and holding them to few, if any, regulatory requirements. This would strip the States of the ability and fidelity to regulate beneficiary protections that exist to protect their citizens.

Federally certifying AHPs will allow selective choice of which benefits are provided and which persons can enroll. This is a complete and total disservice to all individuals and citizens in a State's health insurance market. Association health plans currently exist and operate in New York State, serving many thousands of beneficiaries and avail New Yorkers' protections, benefits guarantees, and avenues for appeal through the Department of Financial Services.

This bill does nothing to offer guaranteed affirmative coverage. It would permit preexisting conditions as a legitimate reason to exclude individuals. It has no minimum threshold for anything resembling essential health benefits, and it fails to offer a requirement for the actuarial value of the insurance product to cover total health costs.

What then remains is not a health plan. In fact, what remains is strikingly similar to what the American Health Care Act purports to offer millions of Americans: less coverage for those enrolled and more expense for those who are too sick, too old, and too poor to be approached by an AHP.

AHPs would lead to higher costs for seniors and individuals who are sicker and will dilute the risk pool of entire States, leading to higher premiums and out-of-pocket expenses. Where the American Health Care Act will unilaterally hurt all Americans, H.R. 1101 would accomplish the same harm directed at the sickest and most underserved in a more prejudicial manner.

Mr. Speaker, I offered an amendment to this bill, which was germane, yet not made in order. My amendment would have protected the rights of the States to regulate association health plans, to include regulation of benefits, consumer protections, and rating restrictions. The goal of my amendment was to ensure that all States and their constituents have the same security and protections that my constituents have benefited from over the past 7 years: consumer protections against surprise billing and adverse selection, provider protection for prompt claim payment and preauthorization, protection for local and regional insurers so that large national insurance companies cannot cherry-pick the good risk.

I certainly believe and would hope that my colleagues on the other side of the aisle support program integrity and protecting our constituents, which is what my amendment would have made clear.

Lastly, I would like to be clear that I am supportive of increasing access to health care that is comprehensive and affordable for all Americans. The bill before us does not do that. The American Health Care Act certainly does not do that.

Mr. Speaker, I urge my colleagues to strongly oppose this rolling back of health care.

Ms. FOXX. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. WALBERG), the chairman of the Subcommittee on Health, Employment, Labor, and Pensions.

Mr. WALBERG. Mr. Speaker, I rise today in support of H.R. 1101, the Small Business Health Fairness Act, a bill that will help people in Michigan and across the country by expanding affordable coverage for workers and their families.

I thank our colleague, Representative SAM JOHNSON of Texas, for introducing this legislation. I really enjoyed hearing the gentleman from Texas and his comments about this being common sense. Representative SAM JOHNSON of Texas defines common sense and patriotism. He has tirelessly championed this bill for years, and it is a pleasure to join him in pushing for these positive reforms.

Mr. Speaker, health care in this country has become simply unaffordable for far too many small businesses and working families. The Patient Protection and Affordable Care Act has proved to be an utter failure for most people in the United States. It is snowballing out of control and rolling over working families and small businesses.

Ninety-five percent of small businesses have reported increased health insurance costs over the past 5 years. A 2015 study by the National Federation of Independent Businesses found that the cost of health insurance is the principal reason that small businesses do not offer coverage.

As a result, since 2008, 36 percent of small businesses with fewer than 10 employees have stopped offering healthcare coverage to their employees. It is not that they don't want to offer healthcare benefits. The truth of the matter is that small businesses have been hit especially hard by the government takeover of health care. Under ObamaCare, the working families I speak to in my district are paying more for less and finding they have fewer options for coverage.

H.R. 1101 is a key part of the third phase of our efforts to reform our healthcare system so it works for all Americans. It aims to increase the negotiating power of small businesses so they can bring down health insurance costs for their employees.

Right now, small businesses are often on an unequal playing field with larger companies and unions. Because they have few employees, small businesses have limited bargaining power when it comes to negotiating for lower insurance costs for their workers.

The SPEAKER pro tempore (Mr. ROGERS of Kentucky). The time of the gentleman from Michigan has expired.

Ms. FOXX. Mr. Speaker, I yield an additional 15 seconds to the gentleman.

Mr. WALBERG. Mr. Speaker, this bill levels the playing field for small businesses, allowing them to band together through association health plans and negotiate the best deals to provide health care at a lower cost. It also represents an important step toward purchasing health insurance across State lines.

Today's vote is an immediate first step to help job creators provide affordable healthcare options to their employees and a transition toward a patient-centered healthcare system.

Mr. Speaker, I urge my colleagues to support this legislation.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 4 minutes to the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Mr. Speaker, again, as someone who was a small-business employer for 27 years and provided health benefits for my staff, I am acutely aware of the challenges in the small-business market which long predate passage of the Affordable Care Act and which is still something that we can do better in terms of helping folks deal with this issue, which, again, is so important because small businesses are the job creators in the American economy.

What I want to sort of point out is that this legislation, in my opinion, is just a complete misfire. Let's, first of all, remind everyone that there are over 670 association health plans existing in America today.

The notion that the Affordable Care Act somehow is smothering or stifling association health plans is, in fact, just factually false. There are many that are in business, providing coverage, as has been said by some of the prior speakers, for people in industries like restaurants, et cetera. Again, we are not talking about some existential threat that is out there in terms of association health plans today.

The guts of this bill—and it is quite extraordinary coming from, again, the Republican Party—is to preempt State Governments from having any say over the solvency and the benefit design of plans that operate under association health plans.

Back in the 1990s, there was a spate of problems with association health plans going belly up because, again, there was no State insurance solvency standards to make sure that there were funds set aside to pay the bills of people who were employed in the businesses that these plans were set up to serve.

As a result, Congress acted. We basically said that the Federal Government was doing a lousy job in terms of protecting patients. And we gave States the ability, through their State insurance departments, to make sure that certain solvency standards were met and, as was stated earlier, that they weren't able to cherry-pick just the healthiest and leave the rest for the other segments of the health insurance industry.

As a result of the fact that we made this change, again, the State insurance commissioners all across America, Republican States and Democratic States, have weighed in. They sent a letter on February 28 pleading with Congress not to do this, not to pass this bill which eliminates their ability to protect the citizens of their States.

So this bill is actually an anti-states' rights bill because it is basically saying the Federal Government is just going to step in and wipe out the way in which these plans operate and just lead, again, a race to the bottom, the lowest threshold of protections for patients; and that is considered healthcare reform or somehow advancing the ball in terms of helping small businesses.

There are many other ways to deal with this issue, and this is not the right one. Again, this is not some new idea that we are debating. This has been back and forth over the years, in the 1990s and the early 2000s. It predates the Affordable Care Act by decades, and it is just an old chestnut that is being thrown out in the floor in the name of some idea to sound like we are doing something for small businesses.

Again, under the Affordable Care Act, we set up a 50 percent tax credit for businesses that qualify for it to make health insurance affordable.

I did two townhalls back in my district. I had a plumber from the next town over who, again, took advantage of that 50 percent tax credit. He saved thousands of dollars in terms of providing health benefits for his small business.

We can expand that tax credit to get a wider universe of small businesses, and that is what we should be doing. We should be building on what is successful, again, not watering down existing patient protection and consumer protection laws that ensure that plans are actually going to have enough funds to pay the bills when people get sick or go to the hospital and certainly not be able to cherry-pick what benefits are considered essential or not.

The SPEAKER pro tempore. The time of the gentleman from Connecticut has expired.

Mr. SCOTT of Virginia. Mr. Speaker, I yield an additional 1 minute to the gentleman.

Mr. COURTNEY. Mr. Speaker, we should not be allowing health plans to decide we are not going to cover maternity or that they can pick and choose what essential benefits that, again, the rest of the universe of businesses have to provide now under the Affordable Care Act, which are, again, based on sound medical research, not political decisions or not just the whims of people who are running health plans, like association health plans.

Again, this is the wrong approach. This is, again, turning the clock backwards. It is not going to provide any protections, and it certainly is not responding to some existential threat of association health plans. There are 672 in operation today. Let's help them with programs like tax credits. Let's not just sort of turn that whole sector of the health insurance marketplace into the Wild West because it is patients who are going to lose. Our citizens are going to lose. We can do better than that as a Congress.

Mr. Speaker, again, I strongly urge a ''no'' vote on this measure.

Ms. FOXX. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. ROE), a distinguished colleague, a member of the committee, and the chair of the Veterans' Affairs Committee.

□ 1430

Mr. ROE of Tennessee. Mr. Speaker, I rise today in strong support of H.R. 1101, the Small Business Health Fairness Act, sponsored by my good friend and true American hero, SAM JOHNSON. I encourage all of my colleagues to do the same. This bill is an important tool to help empower small businesses to offer more affordable healthcare options to their employees.

Mr. Speaker, as a former small-business owner myself, I know that most small-business owners want to do the right thing and offer health insurance to their employees. We did so in my practice.

But many of these businesses are struggling with the cost and complexities of offering health insurance to their employees. ObamaCare has exacerbated this problem for small businesses. Thousands of jobs and thousands of small businesses have closed.

We have a better way. We are going to start by passing the American Health Care Act, which will repeal many of ObamaCare's taxes and mandates and replace it with free market reforms.

But there is much more that can be done. Perhaps the only thing that has prevented ObamaCare from causing even more widespread damage was the success of ERISA, employer-sponsored health insurance.

We believe small businesses deserve the same protections that large businesses do, and that is why we are passing this legislation today. The Small Business Health Fairness Act takes positive steps toward creating a more competitive healthcare marketplace, lowering insurance costs for many small employers.

Mr. Speaker, why would anybody care if association health plans got together and allowed me to purchase insurance across a State line?

I have a community in my district where the State line on one side of the street is Bristol, Virginia, on the other side is Bristol, Tennessee. Why would it matter? Why couldn't I purchase that insurance across the State line if it helped my employees and lowered costs?

And, by the way, Mr. Speaker, the Affordable Care Act is working so well for consumers that 18 out of 23 of the co-ops went broke, leaving hundreds of thousands of people to search for insurance coverage.

For the past 8 years, House Republicans have engaged the administration and encouraged them to work with us to implement a more patient-centered healthcare system; but, instead of working with us on a common goal, they have layered on additional costs for small businesses.

I again want to encourage my colleagues to support H.R. 1101.

Mr. SCOTT of Virginia. Mr. Speaker, would the Chair advise us how much time is available on both sides?

The SPEAKER pro tempore. The gentleman from Virginia has 14½ minutes remaining, and the gentlewoman from North Carolina has 16¾ minutes remaining.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just wanted to point out a few letters that we have received, one from the Diabetes Association, which includes, in part: ''The Association has serious concerns that AHPs would lead to a two-tiered market, in which AHPs offer inadequate coverage to healthy groups only, while State-regulated plans provide adequate coverage with consumer protections but at an increasingly higher premiums. For these reasons, we urge you to oppose the Small Business Health Fairness Act of 2017, H.R. 1101.''

We have also received a letter, Mr. Speaker, from the National Association of Insurance Commissioners. They said in their letter: ''The legislation as written would eliminate all State consumer protections and solvency standards that ensure consumers receive the coverage for which they pay their monthly premium. These protections are the very core of a State regulatory system that has protected consumers for nearly 150 years . . . history has demonstrated that AHP-type entities have done more harm than good to small businesses.''

Mr. Speaker, we also received a letter from The Main Street Alliance, which said: ''In short, H.R. 1101 would result in higher premiums and poorer coverage for the most vulnerable small-business owners, would destabilize the small group market, and would lead small-business owners and employees to assume unnecessary financial risks.''

We also heard from the Consumers Union: ''Consumer's Union has long raised the inadequacies of AHPs . . . and urges Congress to reject them as likely to fragment the insurance risk pool and provide minimal and nonuniform benefits exempt from State benefit mandates.''

We also heard from a long coalition of consumer groups, providers, and labor unions which said that this bill would just move backward to a two-tiered system that makes it harder to purchase comprehensible, affordable coverage for all but a minority of small businesses.

Mr. Speaker, I include in the RECORD these letters.

AMERICAN DIABETES ASSOCIATION,
March 21, 2017.

Hon. PAUL RYAN,
Speaker, House of Representatives, Washington, DC.
Hon. NANCY PELOSI,
Democratic Leader, House of Representatives, Washington, DC.

DEAR SPEAKER RYAN AND LEADER PELOSI: On behalf of the nearly 30 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) is writing to express our strong opposition to the Small Business Health Fairness Act (H.R. 1101). This legislation is nearly identical to legislation considered by previous Congresses and that last passed the House of Representatives in 2003. The Association opposed that legislation and writes now to express our strong concerns with this bill and the impact it will have for people with, and at risk for, diabetes.

The legislation would create federally certified association health plans (AHPs) with the goal of making coverage more affordable for small businesses by allowing them to band together to purchase coverage on behalf of a larger insurance pool. We share the goal of making coverage more affordable, but not at the expense of required consumer protections, signed into law in 47 states, which ensure people with diabetes have access to the services and financial protection they need.

H.R. 1101 would broadly exempt AHPs from critical state benefit standards, solvency rules, and consumer protections, including requirements to cover health services essential to those with diabetes. Specifically, H.R. 1101 would confer on AHPs wide authority to:

Determine benefits to be covered: Other than requiring AHPs to meet limited federal requirements for ERISA-governed plans, H.R. 1101 would give AHPs broad discretion to omit important health benefits.

Determine eligibility for coverage: While H.R. 1101 would require AHPs to comply with ERISA non-discrimination provisions, the AHP board would retain sole discretion to approve applications for participation in the plan and to set premiums based on an employer's health care claims experience.

Maintain inadequate reserves: H.R. 1101 applies federally determined solvency standards that are weaker than state standards, exposing plan members to the risk of insolvency and unpaid medical bills.

Because AHPs would compete with state-regulated plans on an uneven playing field, they would likely cherry-pick healthy small employer groups, making the risk pool in the state-regulated market less healthy and more costly. In addition, those who obtain coverage through an AHP would likely have benefits that lack coverage for essential services and would expose them to higher out-of-pocket costs and potential plan insolvencies. In fact, numerous AHPs offered in the past have gone insolvent and left consumers uninsured and with unpaid medical bills.

The Association has serious concerns that AHPs would lead to a two-tiered market, in which AHPs offer inadequate coverage to healthy groups only, while state-regulated plans provide adequate coverage with consumer protections but at increasingly higher premiums. For these reasons, we urge you to oppose the Small Business Health Fairness Act of 2017, H.R. 1101.

If you have questions or would like to discuss this issue, please contact Rob Goldsmith, Director, Federal Government Affairs.

Sincerely,
LASHAWN MCIVER, MD, MPH,
Senior Vice President of Advocacy, American Diabetes Association.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS & THE CENTER FOR INSURANCE POLICY AND RESEARCH,

February 28, 2017.

Hon. VIRGINIA FOXX,
Chair, Committee on Education and the Workforce, House of Representatives, Washington, DC.
Hon. ROBERT C. SCOTT,
Ranking Member, Committee on Education and the Workforce, House of Representatives, Washington, DC.

DEAR MADAME CHAIRWOMAN AND MR. RANKING MEMBER: The U.S. House Education and the Workforce Committee is once again scheduled to consider legislation that would allow a new category of health insurance company, ''Association Health Plans (AHPs),'' to form and operate outside the authority of state regulators and beyond the reach of proven state consumer protections and solvency laws. This bill, H.R. 1101, would adversely impact consumers and the National Association of Insurance Commissioners (NAIC) urges you to oppose it.

The NAIC, which represents the nation's insurance regulators, shares the sponsors' concern for the growing number of small business owners and employees who cannot afford adequate coverage. However, the root cause of this problem is the steadily rising cost of healthcare merely reflected in premiums, and this legislation would do nothing to address that reality. In fact, we fear the legislation could actually increase the cost of insurance for many small businesses whose employees are not members of an AHP.

Even more troubling than prescribing a treatment that does not address the underlying disease, the legislation would actually harm consumers by further segmenting the small group market, eliminating critical state consumer protections, and could lead to increased fraud and plan failures. This legislation would encourage AHPs to ''cherry-pick'' healthy groups by designing benefit packages and setting rates so that unhealthy groups are disadvantaged. This, in turn, would make existing state risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance. In addition, the legislation as written would eliminate all state consumer protections and solvency standards that ensure consumers receive the coverage for which they pay their monthly premium. These protections are the very core of a state regulatory system that has protected consumers for nearly 150 years. As we have already seen in the past when such plans were allowed under federal law, consumers will be left with unpaid claims and nowhere to turn when they are harmed. A prior law along the lines of H.R. 1101 was repealed because it was found to harm consumers; the same mistake should not be made again.

We recognize that supporters of AHPs are well intentioned, looking for solutions to the same problems we are seeking to address, but history has demonstrated that AHP-type entities have done more harm than good to small businesses. A far broader approach to the existing problems—one that addresses healthcare spending, allows more innovation, and permits more state flexibility—is necessary to bring real relief to small businesses. The federal government and the states need to work with healthcare providers, insurers and consumers to implement effective reforms that will curb spending and make insurance more affordable to small businesses. Rehashing strategies that have failed would not be a step forward. It is time to move on and find more effective solutions.

Sincerely,

TED NICKEL,
NAIC President, Commissioner, Wisconsin Office of the Commissioner of Insurance.
ERIC A. CIOPPA,
NAIC Vice President, Superintendent, Maine Bureau of Insurance.
JULIE MIX MCPEAK,
NAIC President-Elect, Commissioner, Tennessee Department of Commerce & Insurance.
DAVID C. MATTAX,
NAIC Secretary-Treasurer, Commissioner of Insurance, Texas Department of Insurance.

THE MAIN STREET ALLIANCE,
Washington, DC, March 8, 2017.

Chairwoman VIRGINIA FOXX,
Washington, DC.
Ranking Member BOBBY SCOTT,
Washington, DC.

DEAR CHAIRWOMAN FOXX, RANKING MEMBER SCOTT, AND MEMBERS OF THE HOUSE EDUCATION AND WORKFORCE COMMITTEE: On behalf of the Main Street Alliance, I write to express opposition to the ''Small Business Health Fairness Act'' (H.R. 1101). The Main Street Alliance is a national network of small business owners across the country. Access to affordable, high-quality health coverage has been a core concern for small businesses for years, and slowing the skyrocketing rate increases continues to be a top priority for our membership. Unfortunately, the proposed legislation would erode important gains in premium stabilization while causing our business owners to assume unnecessary financial risks.

As you may know, prior to the Affordable Care Act (ACA) small business owners paid substantially more on average for health coverage and received fewer comprehensive benefits than larger companies. They also experienced broad unpredictability in costs, with premiums varying wildly from year to year. One employee's expensive illness could cause the insurance rates for the whole firm to spike in subsequent years.

Critical market reforms instituted through the ACA addressed many of these concerns. Insurance companies in the individual and small-group market—including association health plans—can no longer charge small firms higher premiums based on their business sector, an employee's health status, age, or gender. Nor can they offer sub-par plans that exclude essential services, such as maternity care or pediatric care. Instead, they must now base their pricing on the cost of covering all individuals in the market, not just one firm. Participating in this larger risk pool means that small business owners, like their larger counterparts, are no longer vulnerable to sharp swings in their rates based on the health of a few employees. It also means that they can expect a basic quality assurance with any health plan they select.

H.R. 1101 would undermine these protections by allowing small employer groups and individuals to join together to obtain health insurance through an unregulated association health plan (AHP). These plans would be exempt from the ACA reforms identified above, along with any state laws. This would allow them to ''cherry pick'' good risk through the design of the benefit package or choice of service area. AHPs could also have limited risk simply due to the types of businesses that belong to the association. While AHPs may save money in the short-term by avoiding costs of consumer protections, enrollees would receive less robust coverage and may be left without important protections right when they need them the most.

Furthermore, the bill would destabilize the small group and individual market by exacerbating adverse selection, driving up costs for the most vulnerable enrollees. Under the proposed legislation, AHPs would compete with other small group and individual market plans. The proposed legislation would allow employers with younger, healthier workforces to withdraw their employees from a state's small group market thus leaving behind small businesses with older and sicker employees. While the rates may drop for those businesses that belong to associations, which offer health coverage, premiums will increase for the remaining. This adverse selection would make it harder for higher-cost individuals or groups to obtain coverage.

Finally, the proposed legislation could expose employers and employees to financial ruin. The proposed legislation would allow certain AHPs to self-insure and accept insurance risk. Because of the current regulatory void, AHPs are not subject to state solvency requirements that are in place to ensure insurance companies have sufficient resources to avoid financial failure. As with unregulated multiple employer welfare arrangements, AHPs could experience bankruptcies—leaving millions of small employers and workers without health coverage due to insolvencies.

In short, H.R. 1101 would result in higher premiums and poorer coverage for the most vulnerable small business owners, would destabilize the small group market, and would lead small business owners and employees to assume unnecessary financial risks. The Main Street Alliance strongly urges you to oppose the legislation.

Please feel free to contact Michelle Sternthal, Policy Director for the Main Street Alliance, with any questions.

Sincerely,

AMANDA BALLANTYNE,
National Director.

CONSUMERSUNION,
March 21, 2017.

HOUSE OF REPRESENTATIVES,
Washington, DC.

DEAR REPRESENTATIVE: We are writing today to oppose the Small Business Health Fairness Act (H.R. 1101) and the proposed rules for association health plans.

Today, small businesses are already able to join together to purchase coverage through Association Health Plans (AHPs). These AHPs are currently regulated by the states, just like other insurance in the small group market. H.R. 1101 would allow an AHP to be entirely exempt from state regulation by being self-insured or following the rules of a single state nationwide.

ConsumersUnion has long raised the inadequacies of AHPs as a solution to improving access and strengthening the health of insurance markets, and urges Congress to reject them as likely to fragment the insurance risk pool and to provide minimal and non-uniform benefits exempt from state benefit mandates. These plans would split the healthy from the sick and drive up costs for those who do not enroll in them.

As a non-partisan, independent organization that has advocated for the best consumer products and policies for more than 80 years, we believe that altering the rules for AHPs as proposed in this bill would undermine consumers' access to fairly priced, quality health coverage.

Our objections are that:

AHPs would be offered alongside other small group and individual market plans.

However, they would operate under different rules. Past experience shows this is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals and small businesses. Put another way, this would lead to health risk being segmented with the less healthy consumers excluded from the AHP risk pool. A core, long-held ConsumersUnion principle is to support broad pooling of risk as fairer and more cost-effective for consumers. We do not support lower rates for healthiest consumers at the expense of older or sicker consumers.

This Act would undermine state consumer protection laws by restricting the ability of states to regulate AHPs. This loss of protections could lead to increased fraud, inadequate coverage and consumer-unfriendly benefit designs. In July 2003, Consumer Reports profiled similar plans in a story entitled Phony Health Insurance. The story noted that fraudulent sales and financial instability stiffed consumers for $65 million in unpaid medical bills.

This Act would give AHPs sole discretion to select what type of care they will and will not include in their products; this is a departure from current policy, which only permits AHPs that meet insurance standards set for the individual and small group market. Consumers who buy into these plans will lose the guarantees of care created by the ACA's essential health benefits and actuarial value requirements—likely unknowingly—and will have difficulty knowing what AHPs cover.

It is unlikely that these AHPs will be able to attract enough members to be able to negotiate more effectively with providers, compared to large insurers already operating in these states. Consequently, we do not believe that these designs will lower costs for consumers.

Multiple Employer Welfare Arrangements (MEWAs) once operated in a regulatory vacuum similar to the one proposed through H.R. 1101. Self-funded MEWAs had no clear regulatory authority, as initially it appeared that ERISA exempted them from state-level regulatory oversight. Multiple MEWA bankruptcies resulted, and consumers had limited avenue for redress. In the absence of clear regulatory authority over AHPs, insolvencies could leave millions of small employers and workers without health coverage or redress. Current state solvency standards have a 150 year track record of protecting consumers and should not be undermined.

We believe there are much better, time-tested ways to increase the availability, affordability, and accessibility of health insurance for consumers—approaches that rely on the wise and accepted insurance principles of broad pooling of risks and avoidance of risk selection—without resorting to the detrimental effects of H.R. 1101. We note that the National Association of Insurance Commissioners, as well as the American Academy of Actuaries, has similar, grave concerns about this Act.

Sincerely,

LAURA MACCLEERY,
Vice President, Consumer Policy and Mobilization, Consumer Reports.
LYNN QUINCY,
Associate Director, Health Policy, Consumer Policy and Mobilization, Consumer Reports.

Mr. SCOTT of Virginia. Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I now yield 1½ minutes to the gentleman from Ohio (Mr. CHABOT), the distinguished chairman of the Small Business Committee.

Mr. CHABOT. Mr. Speaker, I want to thank the gentlewoman from North Carolina for her leadership on this issue.

Mr. Speaker, I rise to voice my strong support for H.R. 1101, the Small Business Health Fairness Act. I thank my colleagues from Ways and Means and from the Education and the Workforce Committee for getting this great idea onto paper and moving this bill forward today.

As chairman of the House Small Business Committee, I am always very appreciative to see Members from across this body find solutions for small businesses. That is exactly what this bill is.

For virtually any one of us in this Chamber, it can be said that hundreds of thousands of our constituents depend on small businesses for their livelihoods. They have been looking to those same small businesses for options, as ObamaCare has done the opposite of what it was supposed to do and it has diminished choices for workers.

By allowing small businesses to join together through association health plans, the Small Business Health Fairness Act would give small business employees at least as many choices as those who happen to work for larger companies.

Association health plans have long been a solution suggested by small businesses that share their views with me and other members of the Small Business Committee. This bill puts that idea finally into action.

Mr. Speaker, in our current state of affairs, there are fewer and fewer healthcare options available for hard-working Americans. This bill addresses that problem for our hardest hit small businesses and communities.

While we begin the hard work of making health care not only affordable but worth buying at all, this bill is an important step in giving Americans the certainty and choices that they want. I would urge my colleagues on both sides of the aisle to support this bill.

Mr. SCOTT of Virginia. Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. ALLEN), a member of our committee.

Mr. ALLEN. Mr. Speaker, I thank the chairwoman for her leadership on this important bill.

Mr. Speaker, today I rise in support of H.R. 1101, the Small Business Health Fairness Act.

Since 2008, the number of small businesses offering health insurance to its employees has dwindled nearly 36 percent. The culprit? Well, ObamaCare.

You know, the American people deserve choice. I have lived this reality. I owned and operated a small business for over 40 years back home in Georgia. I know how ObamaCare premium increases hurt and, in some cases, affect a business' ability to provide health care for its employees.

I believe the greatest gift God gave me as a small-business owner was the ability to give others a good job along with the dignity and respect they deserve to provide for their family, their community, their church, and, yes, this Nation.

All hardworking American small-business owners should be able to give their employees these same opportunities. For this reason, I am a strong supporter of the Small Business Health Fairness Act legislation, which would allow small businesses to band together and purchase health care for workers and their families at a lower cost.

Folks, this is innovation. This is what the small business community does. Small businesses are the backbone of America. I will fight for their strength and their survival.

Mr. SCOTT of Virginia. Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I now yield 2 minutes to the distinguished gentleman from Michigan (Mr. MITCHELL), a member of the committee.

Mr. MITCHELL. I thank the gentlewoman from North Carolina for yielding me time.

Mr. Speaker, I rise in support of the Small Business Health Fairness Act. We have all talked a lot about our plan to repeal and replace ObamaCare. This legislation is a key component of our rescue mission for health care in America.

Small businesses have been hit particularly hard by ObamaCare's mandates, skyrocketing costs, and limited choices. Small-business owners, many of whom want to provide health care for their employees, have told me that they are struggling to do so because of ObamaCare.

This legislation would level the playing field for small businesses by allowing them to band together to increase bargaining power to lower costs. It would expand affordable care for families trying to secure health insurance through their employer and lower costs for small businesses with limited resources.

In addition, this bill includes strong protections for patients with pre-existing conditions, a top priority of mine and many of my colleagues as we work for healthcare reform in America.

Today we are acting on our promises to deliver relief from ObamaCare. We are returning power where it belongs, choice where it belongs: to patients and doctors, not Washington.

I urge you to support the Small Business Health Fairness Act.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the bad idea in this plan has been exposed in one of the letters that I mentioned. I said there are a lot of consumer groups, and I just want to name the groups that signed the letter. The American Nurses Association; the Alliance for Retired Americans; the American Cancer Society Cancer Action Network; the American Diabetes Association; the American Federation

of State, County and Municipal Employees; the Association of Reproductive Health Professionals; Bazelon Center for Mental Health Law; Community Catalyst; Consumers Union; Families USA; International Union, United Automobile, Aerospace and Agricultural Implement Workers of America—the UAW; NARAL Pro-Choice America; the National Council of La Raza; the National Education Association; the National Institute for Reproductive Health; National Partnership for Women and Families; National Women's Health Network; Raising Women's Voices for the Health Care We Need; and the Service Employees International Union all oppose this legislation.

Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Minnesota (Mr. LEWIS), a member of our committee.

Mr. LEWIS of Minnesota. Mr. Speaker, I thank the gentlewoman from North Carolina for her leadership here and on the committee as well.

Mr. Speaker, I rise today in support of H.R. 1101, the Small Business Health Fairness Act.

It is amazing as a freshman in this body to watch this debate over what we are trying to do on this side when we know what has already transpired, what has been done:

The Affordable Care Act was going to lower our premiums $2,500. That is what the President said. But they went up by $4,800.

In my home State of Minnesota, we have seen back-to-back increases of 55 and 67 percent, 100,000 people thrown off their plan.

We have got 1,000 counties in this country with just one insurer.

The exchanges are imploding. As young, healthy people can't afford the premiums, they drop out, and the pools only have the older and the sicker.

We have job lock, where people trying to start a small business can't get the same tax advantages or purchasing power as those in big companies.

So what to do? We are going to stabilize the insurance markets through choice and competition, and that is what H.R. 1101 does. It lowers premiums. It enlarges pools. We do that. We must do that to save the health insurance markets and health care in America. That is the agenda of H.R. 1101. That is the agenda of what we are trying to do in global healthcare reform.

So today, as we debate how to fix health care in America, let us not forget the status quo and the debacle it is. So I stand and I urge my colleagues to support this bill, and I further urge my colleagues to finish the job over what we are starting on real healthcare reform.

Mr. SCOTT of Virginia. Mr. Speaker, I just want to quote from another letter that we received from Blue Cross Blue Shield Association. They say: ''We have very serious concerns that H.R. 1101 would create preferential rules that would allow an AHP to be entirely exempt from State regulation by being self-insured or follow the rules of a single State nationwide. Research clearly shows that creating special rules for AHPs and exempting them from State regulation would lead to major problems, including . . . increased insolvency risk . . . increased costs for older, sicker workers.'' Therefore, they are also in opposition to this legislation.

I include in the RECORD the entire letter.

BLUECROSS BLUESHIELD ASSOCIATION,
Washington, DC, March 7, 2017.

Hon. VIRGINIA FOXX,
Chair, Committee on Education and the Workforce, House of Representatives, Washington, DC.

Hon. ROBERT C. SCOTT,
Ranking Member, Committee on Education and the Workforce, House of Representatives, Washington, DC.

DEAR MADAM CHAIRWOMAN AND MR. RANKING MEMBER: The Blue Cross and Blue Shield Association shares your commitment to ensuring small employers are able to provide their employees with high quality, affordable health coverage. However, we are concerned that H.R. 1101, the ''Small Business Health Fairness Act'' would not accomplish this critical goal, as it does not reflect key principles that are essential to ensuring a viable private health insurance market: (1) all competitors should abide by the same set of rules; and (2) states should have clear authority to regulate.

Today, small businesses are able to join together to purchase coverage through association health plans (AHPs). AHPs are currently regulated by the states, just like other insurance in the small group market, and can be a good option for small employers who want to provide their employees with affordable coverage.

We have very serious concerns that H.R. 1101 would create preferential rules that would allow an AHP to be entirely exempt from state regulation by being self-insured or follow the rules of a single state nationwide. Research clearly shows that creating special rules for AHPs and exempting them from state regulation would lead to major problems, including:

Increased insolvency risk: The legislation as drafted would allow for some AHPs to be entirely exempt from state regulation, and instead operate under very limited federal rules and oversight. Past experiences with these kinds of arrangements left millions without health coverage and unpaid claims due to insolvencies.

Increased costs for older, sicker workers: Ultimately, H.R. 1101 would make it much harder for small employers with older, sicker workers to obtain coverage. This is because lower-cost groups would move to a more loosely regulated AHP with fewer benefit and rating rules, while older and/or high-cost groups would remain in traditional insurance plans.

Attached is a compendium of research findings, which provides overwhelming evidence that AHP legislation would make health insurance less accessible, less affordable and less secure for small employers and individual consumers.

We look forward to working with you on solutions that can be taken to improve access and affordability for small employers.

Sincerely,

ALISSA FOX,
Senior Vice President.

□ 1445

Mr. SCOTT of Virginia. Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I have no further speakers, and I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, association plans will help the fortunate few who can get in so long as the members of that association remain healthier than average. But everybody else will pay more. Furthermore, these plans, when they are formed under the bill, will evade important State regulations that could improve solvency and provide important consumer protections.

This is not unlike the philosophy, I guess, on the other replace bill where 24 million fewer people will have insurance; the rest will pay more and get less; while millionaires benefit with huge tax cuts. In this, the fortunate few benefit to the expense of everybody else.

I would hope we would defeat the legislation.

Mr. Speaker, I yield back the balance of my time.

Ms. FOXX. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, some of our colleagues on the other side of the aisle have spent a lot of their time extolling ObamaCare and indicating that we should just stay with what we have, but we all know that ObamaCare is failing.

Republicans are on a rescue mission. We truly do have a better way. As some of my colleagues have stated, we will be passing the American Health Care Act tomorrow. What we are doing here with this bill is something we could not include in that legislation that will round out what it is we want to do with keeping our promise in what we promised last year in our program called A Better Way.

Let me just talk a little bit about the failures of ObamaCare. As my colleagues have said, all the promises were broken: if you wanted to keep your doctor, you could keep your doctor; if you wanted to keep your healthcare plan, you could keep your healthcare plan. Those promises were the most obvious ones that went away. The cost of health care would be going down, and none of that happened.

Mr. Speaker, in addition to that, there is a 25 percent average increase in premiums this year for millions of Americans trapped in ObamaCare, healthcare.gov exchanges. Nearly one-third of U.S. counties have only one insurer offering exchange plans; 4.7 million Americans were kicked off their healthcare plans by ObamaCare. There was $1 trillion in new taxes, mostly falling on families and job creators; 18 failed ObamaCare co-ops out of 23, which my colleague from Tennessee so eloquently pointed out.

These were established as an alternative to the public option. Those healthcare co-ops collapsed, costing

taxpayers nearly 1.9 billion and forcing patients to find new insurance; $53 billion in new regulations requiring more than 176,800,000 hours of paperwork. ObamaCare regulations are driving up healthcare premiums and costing small-business employees at least $19 billion annually.

As I said in the hearing that we had on this bill, the Democrats want a coercive system. Republicans want a system based on freedom.

Today we have an opportunity to make a real difference in the lives of hardworking men and women who are employed by small business. We have an opportunity to deliver much-needed relief to small-business owners who are trying to do the right thing and provide high-quality healthcare coverage for their employees. This legislation represents a truly positive reform that will help lower healthcare costs for working families and put small businesses on a fair and level playing field.

Small businesses are the backbone of our Nation's economy, and there is no reason why they should be at a disadvantage when it comes to finding an affordable healthcare plan. They should be treated in the same fashion as larger businesses and have the ability to craft healthcare plans that meet the needs of their employees. If we want to encourage small businesses to offer health care at a lower cost to workers, this is one commonsense step we can make.

Again, I thank our colleague, Congressman SAM JOHNSON, a true patriot and servant of this country, for his longtime support of this legislation.

I urge my colleagues to vote ''yes'' on H.R. 1101, the Small Business Health Fairness Act, which will help more Americans access high-quality, affordable health care.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate on the bill has expired.

AMENDMENT NO. 1 OFFERED BY MS. HERRERA BEUTLER

Ms. HERRERA BEUTLER. Mr. Speaker, I have an amendment at the desk.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Add at the end of section 6 the following:

(c) COORDINATION WITH EXISTING LAW.—Nothing in this Act shall require plans to become certified under section 802 of the Employee Retirement Income Security Act of 1974, as amended by this Act, or require plans that are not certified under such section to comply with the requirements under part 8 of such Act, except to the extent provided in section 809 of such Act.

The SPEAKER pro tempore. Pursuant to House Resolution 210, the gentlewoman from Washington (Ms. HERRERA BEUTLER) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Washington.

Ms. HERRERA BEUTLER. Mr. Speaker, I thank Chairwoman FOXX and the Committee on Education and the Workforce for their work on this important bill that will benefit small businesses and the families who work for them.

My amendment to the Small Business Health Fairness Act provides a straightforward clarification to ensure that existing association health plans can continue to operate and provide high-quality, affordable care to as many people as possible.

This amendment safeguards association health plans that have been successfully operating under State and Federal law—many of them for decades. We will be making certain that they would not inadvertently be disadvantaged by new Federal legislation or regulation or vulnerable to efforts to restrict access and limit choices.

Why do we need this amendment?

Because I fear what happened in my State will happen in others, where the insurance commissioner attempted to reject 42 out of about 60 association health plans. His office interpreted ObamaCare as giving him a mandate as justification for attempting to eliminate virtually all of these popular plans. By adopting my amendment, it will make crystal clear in the underlying bill that this won't be tolerated, and it will support both existing and future association health plans.

Talk to one of the nearly 400,000 individuals in my home State of Washington who get their care from an association plan, and you will find out why so many Washington businesses renew their plans every year.

Our State has been fortunate to have a robust AHP market that has become essential to providing cost-effective choices to small-business employers, thanks to bipartisan legislation enacted in the mid-1990s. In the case of one association plan operating in my State, roughly 40 percent of participating small-business employers did not previously offer health coverage.

My amendment is supported by the U.S. Chamber of Commerce. In its letter to me, which I include in the RECORD, the U.S. Chamber indicated that it shares my interest in making sure that State-based association health plans that currently exist are able to continue operating in accordance with existing State and Federal law. My amendment is also supported by the Association of Washington Business.

CHAMBER OF COMMERCE OF THE
UNITED STATES OF AMERICA,
Washington, DC, March 20, 2017.

Hon. JAIME HERRERA BEUTLER,
House of Representatives,
Washington, DC.

DEAR CONGRESSWOMAN HERRERA BEUTLER: Thank you for your attention to the concerns raised by the Association of Washington Businesses regarding H.R. 1101, the ''Small Business Health Fairness Act.'' The U.S. Chamber of Commerce has several state chambers of commerce members that provide state-based quality health care coverage to their member companies. The Chamber shares your interest in making sure that the state-based Association Health Plans that currently exist are able to continue to operate in accordance with existing state and federal law without being disadvantaged by this new federal legislation.

The Chamber appreciates your commitment to small businesses and to ensuring that current affordable coverage options continue to be available alongside new options in a nondiscriminatory and fair environment. Thank you for your dedication and efforts, and we look forward to continuing to work with you to advance the priorities and interest of business.

Sincerely,

RANDEL K. JOHNSON.

Ms. HERRERA BEUTLER. Mr. Speaker, I am confident that the underlying legislation before us today will improve the ability of small businesses to access affordable, high-quality health coverage in every State across the country. However, first, this body should, as clearly as possible, ensure that those States that already have successfully operating association health plans are not disrupted, which is what my amendment would do.

I urge my colleagues to support this amendment, and I thank the chairwoman for her work on this.

Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I ask unanimous consent to claim the time in opposition, although I am not opposed to the amendment.

The SPEAKER pro tempore. Is there objection to the request of the gentleman?

There was no objection.

The SPEAKER pro tempore. The gentleman is recognized for 5 minutes.

Mr. SCOTT of Virginia. Mr. Speaker, I appreciate the intent of the amendment offered by the gentlewoman from Washington, which seems to allow health association plans that are currently in existence to continue to operate under existing State and Federal law. In fact, giving States the ability to regulate association plans is very important. That is why I oppose the underlying bill.

The amendment also points out another interesting fact, and that is associations currently exist under current law, and the underlying bill simply unravels most of the regulations that apply to them, and this amendment would at least maintain State regulations.

We know that this bill creates winners and losers. The winners are those who are young and healthy enough to be invited into an association. The losers are small businesses and employers who are older, sicker, or just have more costly health bills. There is no guarantee that plans under this legislation will have the standard level of benefits or consumer protections, and that is why I am disappointed that the majority failed to rule any Democratic amendments submitted to the Rules Committee in order, although each and every one was germane.

The gentleman from New York (Mr. ESPAILLAT), who is a member of the committee, offered an amendment that

would have protected the ability of the States to regulate any association health plan, including regulation related to benefits, consumer protections, and rating restrictions. Representative TORRES from California offered an amendment to ensure that association plans cover 10 essential health benefits under the Patient Protection and Affordable Care Act.

One amendment was offered by Representatives SUSAN DAVIS of California and SUZANNE BONAMICI from Oregon—both committee members—would have required association plans to provide for women's health benefits, including maternity care.

Representatives BONAMICI, DAVIS, and WILSON also offered an amendment to prevent this legislation from taking effect if it would lead to increased premiums for older workers. These older workers will not be able to get into the associations because they would increase average costs of the association, and the point of the association is to get away from high-cost enrollees like older Americans. So these older people will be left out of the pool with other older and sicker workers where they will necessarily be paying more.

It is simple arithmetic. Their amendment would have been particularly important because we know that the Republican replacement plan contains an age tax that will severely disadvantage older populations.

None of the Democratic amendments, although germane, were allowed under the rule, and there does not seem to be any earnest attempt to look to try to correct the shortcomings of the bill. So while I do not intend to oppose this amendment, I do not think the amendment is enough of an improvement of the bill, nor does it change the underlying fact that the legislation does not adequately protect small businesses, workers, and their families, nor does it help those left behind who are not invited into the association who will necessarily be paying more.

Mr. Speaker, if those on the other side of the aisle want to go on a rescue mission, they ought to improve things, not make things worse. For most Americans, this bill will make things worse, and, tomorrow, 24 million Americans will be left out while many others will be paying more for less while millionaires get huge tax cuts. That is not an improvement.

Mr. Speaker, I reserve the balance of my time.

Ms. HERRERA BEUTLER. Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore. The gentlewoman has 2½ minutes remaining.

Ms. HERRERA BEUTLER. Mr. Speaker, I would just like to say that part of the reason this underlying bill is so critical is because we just don't believe one size fits all. When it comes to health coverage, we need to make sure that there are many different options for families, individuals, and businesses. We are clarifying basically a technical change here that allows continued existing plans to operate.

Who can be opposed to existing plans operating and offering more options and more plans?

This is exactly what Republicans are doing right now. We are fighting to make sure that the families and the people we represent have those options and their choices, that they can keep their doctor, that their health premiums will come down, that they can maybe get a plan through their work, or maybe they will be able to get into the individual market and self-insure—options—because one size does not fit all, which is why this bill is crucial and why my amendment to this bill makes it better. That is why we are going to move forward and make sure that more Americans have access to care—not just on paper—but care that gets them to in to the doctor, that gets them the care that they need, whether it is a specialist or a primary care doctor.

Mr. Speaker, I yield back the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I would point out that when one size fits all, everybody can benefit; but when you start picking and choosing winners and losers, some will benefit and many others will lose. Under this bill, a fortunate few who get into association plans will benefit; everybody else loses.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to the rule, the previous question is ordered on the bill, as amended, and on the amendment offered by the gentlewoman from Washington (Ms. HERRERA BEUTLER).

The question is on the amendment by the gentlewoman from Washington (Ms. HERRERA BEUTLER).

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

□ 1500

MOTION TO RECOMMIT

Ms. SHEA-PORTER. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentlewoman opposed to the bill?

Ms. SHEA-PORTER. I am opposed in its current form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Ms. Shea-Porter moves to recommit the bill H.R. 1101 to the Committee on Education and the Workforce, with instructions to report the same back to the House forthwith with the following amendment:

Page 15, after line 22, insert the following: ''(6) SUBSTANCE USE DISORDER TREATMENT.—Notwithstanding subsection (b), the plan provides for coverage for substance use disorder treatment, including opioid use disorder treatment, consistent with the substance use disorder services defined as an essential health benefit by the Secretary under subparagraph (E) of section 1302(b)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)(1)).''.

Ms. SHEA-PORTER (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New Hampshire?

There was no objection.

The SPEAKER pro tempore. The gentlewoman from New Hampshire is recognized for 5 minutes.

Ms. SHEA-PORTER. Mr. Speaker, this is the final amendment to the bill, which will not kill the bill or send it back to committee. If adopted, the bill will immediately proceed to final passage, as amended.

Mr. Speaker, I rise today on behalf of the families and communities across the Nation that are confronting a public health threat of our time: the heroin, fentanyl, and prescription opioid crisis.

This motion would simply ensure that the health insurance plans that today's bill would permit must still cover substance use disorder treatment, including for opioids, as an essential health benefit.

Under current law, we require insurers to cover this treatment. Before the Affordable Care Act, many insurers either didn't cover treatment at all or imposed onerous requirements that blocked people from getting needed care.

H.R. 1101 would roll back that guarantee. It would allow association health plans to return to the kind of skimpy coverage that left so many people struggling with an opioid disorder in dire straits at critical moments. We know there is often a narrow window of opportunity—after an overdose, for example—for someone to commit to treatment, and these are the moments when being able to make a single phone call can make all the difference.

This week's debate about health care is extremely important. Will we decide to work together to improve the American people's access to quality, affordable health care or weaken benefits and kick 24 million or more of our constituents off their plans? We all need to speak up on behalf of those whose lives have been turned around because they can now access health care.

As I talk to families, medical professionals, and law enforcement officials in my district, I hear stories that highlight the dramatic impact that improved access to coverage has had in making treatment a real option for people with substance use disorder. This week, we see that base of coverage is under serious threat. In fact, experts estimate that repealing the Affordable Care Act's coverage provisions would cause about 2.8 million Americans with a substance use disorder to lose some or all of their coverage. The quality of that coverage is also at risk.

Thanks to the Affordable Care Act, insurance must now cover treatment for behavioral health and substance use disorder, just the same as it would cover any other medical service. These parity protections mean insurers must cover treatment for substance use disorder with comparable cost-sharing, with no surprises like annual visit limits, higher copays, or frequent preauthorization requirements and medical necessity reviews.

Badly needed facilities are opening because plans now cover these services. I recently visited a recovery home for pregnant women and new mothers in my district. They were able to open the doors this year in my hometown only because it could rely on Medicaid expansion. Legislation like H.R. 1101 would cause fewer people to have this coverage, meaning fewer facilities can open and treat.

Many of you know that my home State of New Hampshire is on the front lines of the heroin, fentanyl, and prescription opioid crisis. Our communities are struggling, and helping people get treatment is key to turning the tide. I have met people who couldn't be in a recovery facility without Medicaid expansion.

Today, Members of Congress can say to my constituents in New Hampshire and their constituents across this great Nation: we hear you. We know your sons and daughters, your nieces and nephews, your neighbors and friends are struggling, and we have your back.

We believe all Americans deserve good health insurance they can count on when they need it most. We aren't going to pull the rug out from under people who are about to turn their lives around.

I urge my colleagues to support this motion, which would not delay passage of the underlying bill.

Mr. Speaker, I yield back the balance of my time.

Ms. FOXX. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentlewoman from North Carolina is recognized for 5 minutes.

Ms. FOXX. Mr. Speaker, this motion is nothing more than a last-ditch attempt to defeat a commonsense bill that will help expand access to affordable healthcare coverage for working families. In fact, this motion represents the same failed approach to health care we have experienced in recent years.

We have seen what happens when the Federal Government dictates the kind of health insurance individuals can and cannot buy. Healthcare costs skyrocket and patients have fewer choices.

While our Democrat colleagues offer a motion that doubles down on a failed approach to health care, my Republican colleagues and I are offering the American people a better way.

The Small Business Health Fairness Act is about empowering individuals, families, and small-business owners so more Americans have access to affordable healthcare coverage. By rejecting this motion and supporting the underlying bill, we can take an important step in keeping our promise to deliver free-market, patient-centered healthcare solutions.

I urge my colleagues to vote ''no'' on the motion to recommit and ''yes'' on the Small Business Health Fairness Act.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Ms. SHEA-PORTER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of the bill, if ordered; and the motion to suspend the rules and pass H.R. 1238.

The vote was taken by electronic device, and there were—yeas 179, nays 233, not voting 17, as follows:

[Roll No. 185]

YEAS—179

Adams
Aguilar
Barragán
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Cohen
Connolly
Conyers
Cooper
Correa
Costa
Courtney
Crist
Crowley
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Duncan (TN)
Ellison
Engel
Eshoo
Espaillat
Esty
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gonzalez (TX)
Gottheimer
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hanabusa
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson, E. B.
Jones
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Langevin
Larsen (WA)
Lawson (FL)
Lee
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Matsui
McCollum
McGovern
McNerney
Meeks
Meng
Moulton
Murphy (FL)
Nadler
Napolitano
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sires
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NAYS—233

Abraham
Aderholt
Allen
Amash
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bergman
Biggs
Bilirakis
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Bost
Brady (TX)
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Chaffetz
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Dunn
Emmer
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Massie
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Murphy (PA)
Newhouse
Noem
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOT VOTING—17

Bass
Brown (MD)
Carson (IN)
Clyburn
Larson (CT)
Lawrence
Lieu, Ted
McEachin
Moore
Nunes
Payne
Richmond
Rush
Sinema
Slaughter
Takano
Tsongas

□ 1530

Mr. BISHOP of Michigan, Ms. GRANGER, Messrs. GOSAR, and YOUNG of Alaska changed their vote from ''yea'' to ''nay.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. LARSON of Connecticut. Mr. Speaker, on March 22nd, 2017—I was not present for rollcall vote 185. If I had been present for this vote, I would have voted "yea."

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. SCOTT of Virginia. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 236, noes 175, not voting 18, as follows:

[Roll No. 186]

AYES—236

Abraham	Donovan	Knight
Aderholt	Duffy	Kustoff (TN)
Allen	Duncan (SC)	Labrador
Amash	Duncan (TN)	LaHood
Amodei	Dunn	LaMalfa
Arrington	Emmer	Lamborn
Babin	Farenthold	Lance
Bacon	Faso	Latta
Banks (IN)	Ferguson	Lewis (MN)
Barletta	Fitzpatrick	LoBiondo
Barr	Fleischmann	Long
Barton	Flores	Loudermilk
Bergman	Foxx	Love
Biggs	Franks (AZ)	Lucas
Bilirakis	Frelinghuysen	Luetkemeyer
Bishop (MI)	Gaetz	MacArthur
Bishop (UT)	Gallagher	Marchant
Black	Garrett	Marino
Blackburn	Gibbs	Marshall
Blum	Gohmert	Massie
Bost	Goodlatte	Mast
Brady (TX)	Gosar	McCarthy
Brat	Gottheimer	McCaul
Bridenstine	Gowdy	McClintock
Brooks (AL)	Granger	McHenry
Brooks (IN)	Graves (LA)	McKinley
Buchanan	Graves (MO)	McMorris Rodgers
Buck	Griffith	McSally
Bucshon	Grothman	Meadows
Budd	Guthrie	Meehan
Burgess	Harper	Messer
Byrne	Harris	Mitchell
Calvert	Hartzler	Moolenaar
Carter (GA)	Hensarling	Mooney (WV)
Carter (TX)	Herrera Beutler	Mullin
Chabot	Hice, Jody B.	Murphy (PA)
Chaffetz	Higgins (LA)	Newhouse
Cheney	Hill	Noem
Coffman	Holding	Nunes
Cole	Hollingsworth	Olson
Collins (GA)	Huizenga	Palazzo
Collins (NY)	Hultgren	Palmer
Comer	Hunter	Paulsen
Comstock	Hurd	Pearce
Conaway	Issa	Perry
Cook	Jenkins (KS)	Peterson
Costello (PA)	Jenkins (WV)	Pittenger
Cramer	Johnson (LA)	Poe (TX)
Crawford	Johnson (OH)	Poliquin
Cuellar	Johnson, Sam	Posey
Culberson	Jones	Ratcliffe
Curbelo (FL)	Jordan	Reed
Davidson	Joyce (OH)	Reichert
Davis, Rodney	Katko	Renacci
Denham	Kelly (MS)	Rice (SC)
Dent	Kelly (PA)	Roby
DeSantis	King (IA)	Roe (TN)
DesJarlais	King (NY)	Rogers (AL)
Diaz-Balart	Kinzinger	Rogers (KY)
Rohrabacher	Shimkus	Wagner
Rokita	Shuster	Walberg
Rooney, Francis	Simpson	Walden
Rooney, Thomas J.	Smith (MO)	Walker
	Smith (NE)	Walorski
Ros-Lehtinen	Smith (NJ)	Walters, Mimi
Roskam	Smith (TX)	Weber (TX)
Ross	Smucker	Webster (FL)
Rothfus	Stefanik	Wenstrup
Rouzer	Stewart	Westerman
Royce (CA)	Stivers	Williams
Russell	Taylor	Wilson (SC)
Rutherford	Tenney	Wittman
Sanford	Thompson (PA)	Womack
Scalise	Thornberry	Woodall
Schrader	Tiberi	Yoder
Schweikert	Tipton	Young (AK)
Scott, Austin	Trott	Young (IA)
Sensenbrenner	Turner	Zeldin
Sessions	Upton	
	Valadao	

NOES—175

Adams	Fudge	Nadler
Aguilar	Gabbard	Napolitano
Barragán	Gallego	Neal
Beatty	Garamendi	Nolan
Bera	Gonzalez (TX)	Norcross
Beyer	Green, Al	O'Halleran
Bishop (GA)	Green, Gene	O'Rourke
Blumenauer	Grijalva	Pallone
Blunt Rochester	Gutiérrez	Panetta
Bonamici	Hanabusa	Pascrell
Boyle, Brendan F.	Hastings	Pelosi
	Heck	Perlmutter
Brady (PA)	Higgins (NY)	Peters
Brownley (CA)	Himes	Pingree
Bustos	Hoyer	Pocan
Butterfield	Huffman	Polis
Capuano	Jackson Lee	Price (NC)
Carbajal	Jayapal	Quigley
Cárdenas	Jeffries	Raskin
Cartwright	Johnson (GA)	Rice (NY)
Castor (FL)	Johnson, E. B.	Rosen
Castro (TX)	Kaptur	Roybal-Allard
Chu, Judy	Keating	Ruiz
Cicilline	Kelly (IL)	Ruppersberger
Clark (MA)	Kennedy	Ryan (OH)
Clarke (NY)	Khanna	Sánchez
Clay	Kihuen	Sarbanes
Cleaver	Kildee	Schakowsky
Cohen	Kilmer	Schiff
Connolly	Kind	Schneider
Conyers	Krishnamoorthi	Scott (VA)
Cooper	Kuster (NH)	Scott, David
Correa	Langevin	Serrano
Costa	Larsen (WA)	Sewell (AL)
Courtney	Larson (CT)	Shea-Porter
Crist	Lawson (FL)	Sherman
Crowley	Lee	Sires
Cummings	Levin	Smith (WA)
Davis (CA)	Lewis (GA)	Soto
Davis, Danny	Lipinski	Speier
DeFazio	Loebsack	Suozzi
DeGette	Lofgren	Swalwell (CA)
Delaney	Lowenthal	Thompson (CA)
DeLauro	Lowey	Thompson (MS)
DelBene	Lujan Grisham, M.	Titus
Demings		Tonko
DeSaulnier	Luján, Ben Ray	Torres
Deutch	Lynch	Vargas
Dingell	Maloney, Carolyn B.	Veasey
Doggett		Vela
Doyle, Michael F.	Maloney, Sean	Velázquez
	Matsui	Visclosky
Ellison	McCollum	Walz
Engel	McEachin	Wasserman Schultz
Eshoo	McGovern	
Espaillat	McNerney	Waters, Maxine
Esty	Meeks	Watson Coleman
Evans	Meng	Welch
Foster	Moulton	Wilson (FL)
Frankel (FL)	Murphy (FL)	Yarmuth

NOT VOTING—18

Bass	Hudson	Rush
Brown (MD)	Lawrence	Sinema
Carson (IN)	Lieu, Ted	Slaughter
Clyburn	Moore	Takano
Fortenberry	Payne	Tsongas
Graves (GA)	Richmond	Yoho

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1539

Mr. CLEAVER changed his vote from ''aye'' to ''no.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. YOHO. Mr. Speaker, I was unavoidably detained. Had I been present, I would have voted "yea" on rollcall No. 186.

Mr. FORTENBERRY. Mr. Speaker, I was inadvertently detained. Had I been present, I would have voted "yea" on rollcall No. 186.

SECURING OUR AGRICULTURE AND FOOD ACT

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill (H.R. 1238) to amend the Homeland Security Act of 2002 to make the Assistant Secretary of Homeland Security for Health Affairs responsible for coordinating the efforts of the Department of Homeland Security related to food, agriculture, and veterinary defense against terrorism, and for other purposes, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. DONOVAN) that the House suspend the rules and pass the bill.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 406, nays 6, not voting 17, as follows:

[Roll No. 187]

YEAS—406

Abraham	Bucshon	Crawford
Adams	Budd	Crist
Aderholt	Burgess	Crowley
Aguilar	Bustos	Cuellar
Allen	Butterfield	Culberson
Amodei	Byrne	Cummings
Arrington	Calvert	Curbelo (FL)
Babin	Capuano	Davidson
Bacon	Carbajal	Davis (CA)
Banks (IN)	Cárdenas	Davis, Danny
Barletta	Carter (GA)	Davis, Rodney
Barr	Carter (TX)	DeFazio
Barragán	Cartwright	DeGette
Barton	Castor (FL)	Delaney
Beatty	Castro (TX)	DeLauro
Bera	Chabot	DelBene
Bergman	Chaffetz	Demings
Beyer	Cheney	Denham
Biggs	Chu, Judy	Dent
Bilirakis	Cicilline	DeSantis
Bishop (GA)	Clark (MA)	DeSaulnier
Bishop (MI)	Clarke (NY)	DesJarlais
Bishop (UT)	Clay	Deutch
Black	Cleaver	Diaz-Balart
Blackburn	Coffman	Dingell
Blum	Cohen	Doggett
Blumenauer	Cole	Donovan
Blunt Rochester	Collins (GA)	Doyle, Michael F.
Bonamici	Collins (NY)	
Bost	Comer	Duffy
Boyle, Brendan F.	Comstock	Duncan (SC)
	Conaway	Duncan (TN)
Brady (PA)	Connolly	Dunn
Brady (TX)	Conyers	Ellison
Brat	Cook	Emmer
Bridenstine	Cooper	Engel
Brooks (AL)	Correa	Eshoo
Brooks (IN)	Costa	Espaillat
Brownley (CA)	Costello (PA)	Esty
Buchanan	Courtney	Evans
Buck	Cramer	Farenthold